Positive Direction and Associates, Inc. 50 Fountain Plaza (1400)
(Authorization to Release Information) Buffalo, NY 14202

Patient Name:	Record Number:
Patient Address:	Patient mailing address:

Positive Direction and Associates, Inc. (PDA, Inc.) has my permission to **release or obtain** information indicated in item #1 below. This information may include reports about my physical, mental health condition, substance use disorders as well as school records.

I can change my mind about this release by telling PDA, Inc. in writing that I do not want any further information to be given out. I understand that information disclosed according to this consent may be subject to re-disclosure and will no longer be subject to the HIPPA privacy requirements. This will not affect actions already taken with my permission.

My permission to release or obtain information expires on date _____ or no later than one year from the date of signature, whichever is sooner.

1. What information is to be released / obtained?

_____

2. Who is releasing / receiving this information? (Insert the full name of this person or organization)

Name: *Dr. Davina Moss-King (Positive Direction and Associates, Inc.)*

Title: *President*

Address: *50 Fountain Plaza Suite 1400 Buffalo, New York 14202 (716) 906-8118 [p/f]*

3. Who is receiving / receiving this information : (Insert the full name of the person or organization)

Name: _____

Title: _____

Address: _____

4. Why is this information needed? _____

_____

I have read all of the information on this form. I understand and agree to its contents.

_____ _____

Patient Signature **Date**